

Executive Office: P.O. Box 1109 GT, Mary Street, Grand Cayman, Cayman Islands BWI
 Administrative Office: CNA Insurance Companies, P.O. Box 305153, Nashville TN 37230-5153 USA

Insured's Name _____ Policy Number _____

I, _____, Insured/Owner hereby request the CNA International Life Company to change the above numbered policy as follows:

- Reduction in Face Amount** **New Amount:** _____
- Removal of Rider** **Rider Type:** _____
- Other** **Comments:** _____

***The information requested below is not necessary on persons whose benefits are not changing. If the answer to a question is Not Applicable, please indicate this next to each appropriate question.**

The following declarations made by the Insured/Owner are a part of this application:

1. To the best of your knowledge and belief is the Insured disabled? (This question to be answered if the policy includes a disability benefit.) Yes No Not Applicable

2. To the best of your knowledge and belief, has the person(s) whose benefits are changing or who is being added consulted any physician or been hospitalized within the last 5 years other than as admitted on the original application? Yes No

3. Complete additional person information below if coverage is in effect or is being added.

Full Names of Covered Person(s)	Relationship	Date of Birth	Sex	Height	Weight	Life Insurance In Force	Accidental Death Benefit or Principal Sum
a. _____	(Insured)	_____	_____	_____	_____	_____	_____
b. _____	(Spouse)	_____	_____	_____	_____	_____	_____
c. _____							
d. _____							
e. _____							

4. Occupation _____ Duties _____
 Employer _____ Address _____
Street City Country

5. Within the last 5 years, to the best of your knowledge and belief have you or any (proposed) covered person(s) had:

	Insured		Add'l Person	
	Yes	No	Yes	No
a. Heart attack, heart disease, heart murmur, stroke, high blood pressure, diabetes or kidney disease?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Sugar or albumin in urine?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Tumors or cancer?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Impairment of hearing or vision?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Any mental or physical disorders during the past five years, not listed above?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. X-rays, electrocardiograms, blood studies or other diagnostic tests?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

6. To the best of your knowledge and belief have you or any (proposed) covered person(s) been a patient in a hospital, sanitarium or institution or been advised to enter the same for treatment or diagnosis? Yes No Yes No

7. To the best of your knowledge and belief have you or any (proposed) covered person(s) engaged in any type of flying as a pilot or crew member, skin, scuba or skydiving, racing or other hazardous activities within the past five years? (If yes, complete the appropriate Avocation Questionnaire.) Yes No Yes No

8. Have you or the (proposed) covered person(s) smoked a cigarette within the last 12 months? Yes No

9. Beneficiary for: _____
 Additional Person Rider _____

Notice To Proposed Insured(s)

Detach—leave with applicant

In order to properly underwrite and administer your insurance coverage we must collect certain necessary and helpful information concerning your insurability. You are our most important source of information, but we must also contact other sources, including medical professionals and institutions, employers, and other insurance companies.

We may obtain an investigative consumer report whereby information as to your character, general reputation, and personal characteristics are secured through personal interviews with your friends, neighbors and others with whom you are acquainted.

In some situations, and in compliance with applicable law, we may disclose necessary items of information to third parties without your specific authorization.

(Please see Notice Regarding Medical Information Bureau.)
Thank you for your application for insurance .

LV206-274-B

Notice Regarding Medical Information Bureau

Please Read Carefully

Information regarding your insurability will be treated as confidential. CNA International Life Company or their reinsurer(s) may, however, make a brief report to the Medical Information Bureau, a nonprofit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information in its file.

CNA International Life Company or their reinsurer(s) may also make information in its file available to other life insurance companies to whom you may apply for life or health insurance, or to whom you submit a claim for benefits.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of the Bureau's information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112 USA.

LV203-902-A